

CLIENT DEMONSTRATION PROJECT: PROVIDER-LEVEL FORM

For definitions of the term used through out this instrument, please refer to the accompanying Instruction Manual. All providers are required to complete this instrument once each year. For all close-ended questions (questions with check-boxes) provide only ONE response per question, unless instructed otherwise.

Provider and Contact Information

1. Provider name: _____

2. Provider address:

Street: _____

City: _____

State: _____ ZIP code: _____

Provider ID # _____

Taxpayer ID #: ____ - ____ - ____ - ____ - ____ - ____

3. Contact information:

a. Name: _____

b. Title: _____

c. Phone: (____) ____ - ____ - ____

d. Fax: (____) ____ - ____ - ____

e. E-mail: _____

4. Person completing this form:

a. Name: _____

b. Phone: (____) ____ - ____ - ____

c. E-mail: _____

All subsequent questions regarding "clients" should be answered relative to the reporting scope you select here.

7. Provider type:

- 1- ☐ Hospital or university-based clinic
- 2- ☐ Publicly funded community health center
- 3- ☐ Publicly funded community mental health center
- 4- ☐ Other community-based service organization (CBO)
- 5- ☐ Health department
- 6- ☐ Substance abuse treatment center
- 7- ☐ Solo/group private medical practice
- 8- ☐ Agency reporting for multiple fee-for-service providers
- 9- ☐ PLWHA coalition
- 10- ☐ VA facility
- 11- ☐ Other facility

8. (Answer only if provider type in #7 is "Publicly funded community health center.") Did you receive funding under Section 330 of Public Health Service Act (funds community health centers, migrant health centers, and health care for the homeless) during this reporting period?

- 0- ☐ No
- 1- ☐ Yes
- 2- ☐ Don't know/unsure

Reporting and Program Information

5. Calendar year for reporting:

Start date: ____ / ____ / ____ (mm/dd/yyyy)

End date: ____ / ____ / ____ (mm/dd/yyyy)

6. Reporting scope:

- 1- ☐ ALL clients receiving a service **ELIGIBLE** for Title I, II, III, or IV funding
- 2- ☐ ONLY clients receiving a Title I, II, III, or IV **FUNDED** service

9. Ownership Status:

- 1- ☐ Public/local
- 2- ☐ Public/state
- 3- ☐ Public/Federal
- 4- ☐ Private, non-profit (not faith-based)
- 5- ☐ Private, for-profit
- 6- ☐ Unincorporated
- 7- ☐ Faith-based organization
- 8- ☐ Other

All grantees and providers must use reporting scope "1" unless they have permission from their HRSA project officer to use "2."

10. Source of Ryan White CARE Act Funding (Check all that apply):

- 1- ☐ Title I
 1- ☐ Title II
 1- ☐ Title III
 1- ☐ Title IV
 1- ☐ Title IV Adolescent Initiative

11. Indicate the amount of funding received during this reporting period for ALL the following categories (rounded to the nearest whole dollar):

\$ _____ Title I
 \$ _____ Title II
 \$ _____ Title III
 \$ _____ Title IV

12. Indicate the amount of Title I, II, III, or IV Ryan White CARE Act funds EXPENDED on oral health care:

\$ _____ Oral health care

13. During this reporting period, did you provide the grantee with support in any of the following areas?

	No	Yes
a. Planning or evaluation	0- <input type="checkbox"/>	1- <input type="checkbox"/>
b. Administrative or technical support	0- <input type="checkbox"/>	1- <input type="checkbox"/>
c. Fiscal intermediary services	0- <input type="checkbox"/>	1- <input type="checkbox"/>
d. Technical assistance	0- <input type="checkbox"/>	1- <input type="checkbox"/>
e. Capacity development	0- <input type="checkbox"/>	1- <input type="checkbox"/>
f. Quality management	0- <input type="checkbox"/>	1- <input type="checkbox"/>

14. Did you administer an AIDS Drug Assistance Program (ADAP) or local pharmaceutical assistance program that provides HIV/AIDS medication to clients during this reporting period?

- 0- ☐ No (Skip to #15.)
 1- ☐ Yes

a. Type of program administered:

- 1- ☐ State ADAP
 2- ☐ Local pharmaceutical assistance program that provides HIV/AIDS medications to clients

15. Did you provide a Health Insurance Program (HIP) during this reporting period?

- 0- ☐ No
 1- ☐ Yes

16. Indicate which of the following populations were especially targeted for outreach or services during this reporting period. (Check all that apply.)

- 1- ☐ All adolescents
 1- ☐ Children
 1- ☐ Gay, lesbian, bisexual, transgendered adults
 1- ☐ Gay, lesbian, bisexual, transgendered, and questioning youth
 1- ☐ Homeless
 1- ☐ Incarcerated persons
 1- ☐ Injection drug users
 1- ☐ Migrant or seasonal farm workers
 1- ☐ Non-injection drug users
 1- ☐ Parolees
 1- ☐ Race/ethnic minorities/communities of color
 1- ☐ Runaway or street youth
 1- ☐ Rural populations other than migrant or seasonal farm workers
 1- ☐ Women
 1- ☐ Other
 If other, specify _____

17. Which of the following categories best describe your agency? An agency in which ... (Check all that apply.)

- 1- ☐ Racial/ethnic minority group members make up greater than 50% of the agency's board members
 1- ☐ Racial/ethnic minority group members make up greater than 50% of the agency's professional/clinical staff members in HIV direct services
 1- ☐ Solo or group private health care practice in which greater than 50% of the professional/clinical staff are racial/ethnic minority group members
 1- ☐ Other "traditional" provider that has historically served racial/ethnic minority patients/clients but does not meet the criteria above
 1- ☐ Other type of agency or facility (Only choose if none of the above applies.)

18. Total paid staff, in FTEs, funded by any Title of the CARE Act:

_____ Paid staff FTEs

19. Total volunteer staff, in FTEs, dedicated to HIV care:

_____ Volunteer staff FTEs

HIV Counseling and Testing

20. Was HIV counseling and testing provided as part of your program during this reporting period?

- 0- ☐ No (Skip to #30.)
1- ☐ Yes

21. Did your agency provide HIV testing to infants during this reporting period?

- 0- ☐ No
1- ☐ Yes

- a. Indicate the number of infants tested _____
b. Indicate the number who were HIV positive _____

22. Were Ryan White CARE Act funds used to support HIV counseling and testing services?

- 0- ☐ No (Skip to question 30, if you selected reporting scope 2 for question 6 and do not wish to continue with this section.)
1- ☐ Yes

23. How many individuals received HIV pretest counseling during this reporting period?

_____ Confidential
_____ Anonymous

24. Of the individuals who received HIV pretest counseling (See #23), how many were tested for HIV antibodies during this reporting period?

_____ Confidential
_____ Anonymous

25. Of the individuals who received HIV pretest counseling and were tested for HIV antibodies during this reporting period (See #24), how many had a positive test result during this reporting period?

_____ Confidential
_____ Anonymous

26. Of the individuals who received HIV pretest counseling and were tested for HIV antibodies during this reporting period (See #24), how many received HIV post-test counseling during this reporting period, regardless of test results?

_____ Confidential
_____ Anonymous

27. Of the individuals who tested POSITIVE (See #25), how many did NOT return for HIV post-test counseling, during this reporting period?

_____ Confidential
_____ Anonymous

28. Of the individuals who tested positive (See #25), how many became new patients at your clinic during this reporting period?

_____ Confidential
_____ Anonymous

29. Did your program offer partner notification services during this reporting period?

- 0- ☐ No (Skip to #30.)
1- ☐ Yes

a. Indicate the number of at-risk partners notified during this reporting period:

_____ Number of at-risk partners notified

Title III Program Information

30. Cost and revenue of primary care* and other program services* during this reporting period:

a. Total cost of providing services

\$ _____ Primary care
\$ _____ Other program services

b. Title III grant funds expended

\$ _____ Primary care (excluding pharmaceuticals)
\$ _____ Other program services
\$ _____ Pharmaceuticals

c. Direct collections from patients

\$ _____ Primary care
\$ _____ Other program services

d. Reimbursements received from third party payer(s)

\$ _____ Primary care
\$ _____ Other program services

e. All other sources of income

\$ _____ Primary care
\$ _____ Other program services

*Includes medical, subspecialty care, dental, nutrition, mental health, and substance abuse treatment, and pharmacy services; radiology, laboratory and other tests for diagnosis and treatment planning; HIV counseling and testing and the cost of making and tracking referrals for medical care.

*Includes case management and eligibility assistance, outreach, social work, prevention education and harm reduction. If you are providing a Title III-eligible service, include it, even if it is not being funded under your grant.

31. Were services available through your Early Intervention Services (EIS) program provided at more than one site during this reporting period?

0- ☐ No (Skip to #32.)

1- ☐ Yes

a. If yes, how many sites provided EIS services during this reporting period? _____

32. Please indicate which of the following primary care services were made available to your HIV positive clients during this reporting period.

	Not provided	Yes, within the EIS program	Yes, through referral
a. Ambulatory/outpatient medical care		1- <input type="checkbox"/>	
b. Dermatology	0- <input type="checkbox"/>	1- <input type="checkbox"/>	2- <input type="checkbox"/>
c. Dispensing of pharmaceuticals	0- <input type="checkbox"/>	1- <input type="checkbox"/>	2- <input type="checkbox"/>
d. Gastroenterology	0- <input type="checkbox"/>	1- <input type="checkbox"/>	2- <input type="checkbox"/>
e. Mental health services	0- <input type="checkbox"/>	1- <input type="checkbox"/>	2- <input type="checkbox"/>
f. Neurology	0- <input type="checkbox"/>	1- <input type="checkbox"/>	2- <input type="checkbox"/>
g. Nutritional counseling	0- <input type="checkbox"/>	1- <input type="checkbox"/>	2- <input type="checkbox"/>
h. Obstetrics/Gynecology	0- <input type="checkbox"/>	1- <input type="checkbox"/>	2- <input type="checkbox"/>
i. Optometry/Ophthalmology	0- <input type="checkbox"/>	1- <input type="checkbox"/>	2- <input type="checkbox"/>
j. Oral health care	0- <input type="checkbox"/>	1- <input type="checkbox"/>	2- <input type="checkbox"/>
k. Rehabilitation services	0- <input type="checkbox"/>	1- <input type="checkbox"/>	2- <input type="checkbox"/>
l. Substance abuse services	0- <input type="checkbox"/>	1- <input type="checkbox"/>	2- <input type="checkbox"/>
m. Other services	0- <input type="checkbox"/>	1- <input type="checkbox"/>	2- <input type="checkbox"/>

33. How many unduplicated patients who are HIV positive were referred outside the EIS program for any health service that was not available within the EIS program during this reporting period? _____

PROVIDER-LEVEL FORM COMPLETE.